2. Disproportionate Share Payment (Continued)

(B) For a hospital, the low income utilization rate is the sum (expressed as a percentage) of the fraction calculated as follows:

- o Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from the state and local governments in a cost reporting period, divided by the total amounts of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; plus,

- o The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third party or personal resources), less cash subsidies received from state and local governments in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan), that is, reductions in charges given to other third party payers such as HMOs, Medicare or Blue Cross.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
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2. Disproportionate Share Payment (Continued)

3. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a Medicaid State Plan. In the case of a hospital located in a rural area, (that is, an area outside of a Metropolitan Statistical Area as defined by the Executive Office of Management and Budgets), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. An obstetrician in an urban setting is defined as a board certified obstetrician with staff privileges at the urban hospital who performs non-emergency obstetric procedures.

The above section does not apply to a hospital which:

- The inpatients are predominantly individuals under 18 years of age; or,
- Does not offer non-emergency obstetric services as of December 21, 1987.

Hospitals must notify the Arkansas Medicaid Program immediately of obstetrical physician staffing changes that affect their disproportionate share eligibility according to the above criteria. Hospitals will not receive disproportionate share payments for any period of time in which the hospital does not meet the obstetrical physician criteria. The State Medicaid Program will verify/audit for any changes in the above obstetrical physician status.

4. Effective July 1, 1995, the hospital must have, at a minimum, a Medicaid Utilization Rate (MUR) of one percent.

STATE Arkansas
DATE RECD MAY 25 1995
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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: July 1, 1995

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2. Disproportionate Share Payment (Continued)

General DSH Payment Provisions Applicable to all DSH Providers

All disproportionate share payments will be based on desk reviewed cost report information and statistics.

The annual disproportionate share payment adjustment to each disproportionate share hospital shall not exceed the limit for that hospital.

The calculation of the limit is as follows:

The limit applicable to disproportionate share payment adjustments is composed of two parts. The first part of the limit is the Medicaid "shortfall." The "shortfall" is the cost of services furnished to Medicaid patients, less the amount paid under the non-disproportionate share payment method under the State Plan.

The second part of the formula is the cost of services provided to patients who have no health insurance or source of third party payment for services provided during the year, less the amount of payments made by these patients.

Disproportionate Share Hospital Limit = M + U

M = Cost of Services to Medicaid patients, less the amount paid by the State under the non-disproportionate share payment provisions of the State Plan

U = Cost of Services to Uninsured Patients, less any cash payments made by them

Cost of Services

The definition of the cost of services includes all inpatient costs allowable under the Medicare principles of reasonable cost reimbursement.

Uninsured Patients

Uninsured patients is defined as patients who do not possess health insurance or do not have a source of third party payment for services provided, including individuals who do not possess health insurance which applies to services for which the individual sought treatment.

2. Disproportionate Share Payment (Continued)

If the total of all disproportionate share payment amounts for all disproportionate share hospitals (acute care, inpatient psychiatric, rehabilitative hospitals and border city hospitals) exceed in any given year the federally determined disproportionate share allotment for Arkansas, the disproportionate share payments will be reduced proportionately among disproportionate share hospitals to a level in compliance with the federal disproportionate share allotment. The following cities which are located within a fifty (50) mile trade area are considered bordering cities: Poplar Bluff, Missouri; Greenville, Mississippi; Poteau, Oklahoma; Memphis, Tennessee and Texarkana, Texas.

Rate Appeal Process

Participating hospitals are provided the following mechanism to appeal their disproportionate share eligibility and/or rate.

A. **All hospitals will be notified of their eligibility status for the disproportionate share payment and of this disproportionate rate, by certified mail. A hospital administrator may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services.**

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DATE APP'D OCT 27 1995
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HCFA 179 95-26
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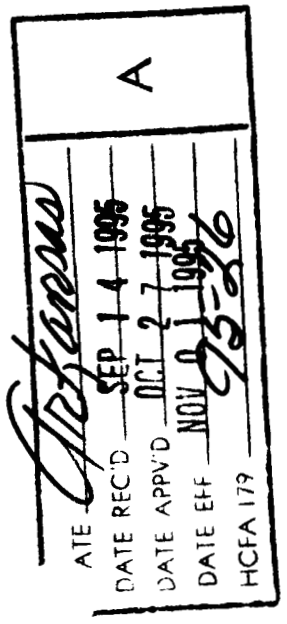
SUPERSEDES: TN • 95-15

2. Disproportionate Share Payment (Continued)

This request must be received within 20 calendar days following receipt of the certified letter which notifies the hospital of their disproportionate eligibility status and/or rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference if he wishes for a full explanation of the factors involved in the program decision. Following review of the appeal request, the Assistant Director will notify the hospital of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

B. If the Assistant Director's, Division of Medical Services, decision is unsatisfactory, the facility may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the Arkansas Hospital Association and a member of the DHS Management Staff who will serve as chairman.



The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question within 15 calendar days after receipt of a request for such appeal. The question will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services for approval.

3. Reimbursement for Inpatient Hospital Services for Children Under Age One (or Children that are Hospitalized on Their First Birthday)

Medically necessary inpatient hospital services furnished to children under age one (or children that are hospitalized on their first birthday) will be exempt from any dollar limits on any inpatient hospital service.

Inpatient hospital services for these individuals will be cost settled separately from all other Medicaid recipients and no dollar limits will be applied.

Arkansas Medicaid will not consider these costs in the Medicare TEFRA rate of increase limit computation.

STATE AR
DATE RECD MAY 31 1991
DATE APP'D DEC 23 1991
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HCFA ID 91-20

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Supersedes: 89-18

ADDENDUM TO "ARKANSAS TITLE XIX INPATIENT
HOSPITAL REIMBURSEMENT MANUAL"
PAGES 1-24 SUBMITTED UNDER TN-84-14

Arkansas Department of Human Services
Division of Social Services

Bill Clinton
Governor

Ray Scott
Director

Seventh and Main Streets
P.O. Box 1437
Little Rock, Arkansas 72203

Curtis L. Ivery
Commissioner

September 18, 1984

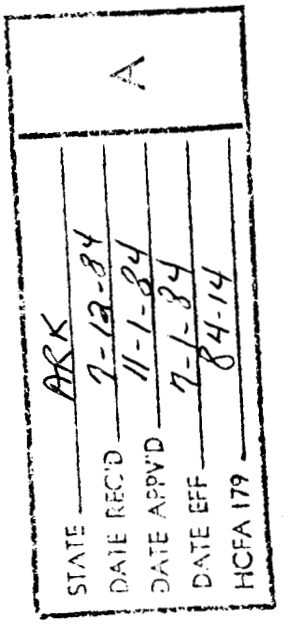
James R. Merryman
Associate Regional Administrator
Division of Program Operations
DHHS/HCFA Regional Office
1200 Main Tower Building
Dallas, TX 75202

Dear Mr. Merryman:

This is to provide the additional information relative to Arkansas Medicaid plan transmittal 84-14 which was requested in your letter dated August 28, 1984.

a) Question: The State's assurances of July 5, 1984, indicate that the proposed methods of payment take into account the situation of hospitals serving a disproportionate number of low income patients in accordance with 42 CFR 447.253(b)(1)(ii)(A). The State is requested to clarify how this requirement has been met under the proposed amendment and whether any special payment provisions have been established for these hospitals. If so, these provisions should be included in the plan.

Response: As outlined in the State Plan revision, the prospective rates are based on each individual hospital's costs as reflected on the 1982 cost report trended through the rate year. Accordingly, hospitals that will incur extra costs in treating a disproportionate share of Medicaid recipients with special needs will be reimbursed appropriately since such costs were used to calculate the prospective rate.



b) Question: The State's assurances also indicate that the proposed method of payment provide that reimbursement for hospital patients receiving services at an inappropriate level of care reflects the level of care actually received under conditions similar to, and in a manner consistent with Section 1861(v)(1)(G) of the Social Security Act. The State is requested

to clarify whether the proposed methods would provide for payments to hospitals for patients who no longer are in need of a hospital level of care and who are awaiting placement in a long term care facility. The State is not required to make these payments. However, if the State intends to do so, the plan should specify the levels of care for which payment will be made along with the methods of payment.

Response: The State, at this time, does not intend to make payments to hospitals for patients awaiting placement in long term care facilities. Should the State wish to make such payments in the future, an appropriate State Plan change would be submitted.

c) Question: Although the proposed amendment provides for the use of the HCFA market basket index to adjust for inflation in computing rates, we have been unable to replicate the inflation factors set forth on page 22 of Attachment 4.19-A. As a result, the State is requested to provide an example of how these factors were derived. The example should show, first, how the base period cost per day is trended forward to July 1, 1984 for a provider with a given fiscal year end and, second, how the cost per day is further adjusted for projected inflation during the State's first rate period (July 1, 1984 - June 30, 1985).

Response: The Inflation Index Calculations contained in Section 1.13 are incorrect. These calculations have been corrected. Please substitute the attached page. This revised page illustrates how the calculations were performed.

d) Question: In Section 1.11 of Attachment 4.19-A, an example of a rate calculation is provided for a hospital with a base period ending June 30, 1982. This example uses an inflation adjustment of 1.24727.

According to Section 1.13 of the attachment, the inflation adjustment factor would be 1.20727. We assume the factor used in the example was hypothetical, we ask the State to confirm this or otherwise explain the discrepancy.

Response: The inflation factor as well as the other cost data, bed days, etc., are hypothetical.

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e) Question: The related information the State submitted indicated that the proposed amendment would result in an increase of 14 percent in the average per diem payment rate. The State is requested to clarify the basis for this projected increase. Specifically, is this projection based on the average per diem payment for the period February 13, 1984 - June 30, 1984, or for the State's entire fiscal year ending June 30, 1984. If the latter period was used, we would note that payments throughout the year were largely based on reasonable cost, and that a 14 percent increase in payments above this level would appear to exceed the rate of increase Medicare would allow under 42 CFR 405.463. As a result, if the State's annual period was used as basis for the projection of increased payment levels under the proposed plan, the State is requested to provide additional support for its assurance that the upper limits set forth under 42 CFR 447.253(b)(2) would not be exceeded under the proposed amendment.

Response: The 14 percent increase indicated in the related information was incorrect. The estimated average per diem of $274 is correct. When compared to the estimated average per diem in effect 1/01/84, which was $252, the rate of increase is 8.7%. The rates in effect 1/01/84 were not reflective of one rate year but included both 1982 and 1983 cost data. When comparing these rates with the Medicare rates, one must consider that unlike Medicare's prospective payment system, there are no pass through costs in the proposed system.

Hopefully this additional information will provide you the data you need to favorably review this plan revision.

If you should have any questions, please do not hesitate to contact us.

Sincerely,

Curtis L. Ivery, Ed D.
Commissioner

CLI/mr
Attachment

STATE ARK
DATE REC'D 7-12-84
DATE APP'D 11-1-84
DATE EFF 7-1-84
HCFA ID 84-14

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